Informational Hearing

HOSPITAL EMERGENCY ROOMS: CHALLENGES AND OPPORTUNITIES

Tuesday, February 24, 2009
1:30 p.m. – 3:30 p.m.

State Capitol
Room 4202

Introduction

Emergency medicine plays a crucial role in our health care system. Hospital emergency departments (EDs) not only provide emergency care in critical situations, but, in practice, EDs often function as a health care safety net for many patients who cannot access timely health care in other settings. Nationally, one of the key challenges facing the health care system, and existing EDs, is a marked increase in ED usage over the last several years.[1] In California, while the demands on emergency care continue to grow, the number of hospital EDs has declined.

Substantial research has been conducted regarding who uses the ED and for what services. Studies indicate when Californians confront limited access to primary care, many turn to EDs for treatment. And, because patients who visit EDs may have delayed seeking treatment, they are often sicker than they would have been had they received timely primary care.[2] Utilization of hospital EDs is a critical issue for the health care delivery system because getting medical care in an ED can be one of the most expensive settings for accessing health care services.

I. Emergency Department Challenges

ED visits increased nationally by 20% over the last decade, and by 10% in California.[3] In 2007, 335 or 78%, of the state's 428 general acute care hospitals had EDs.[4] Since 2000, California has experienced a drop in the number of hospitals with EDs, while the number of ED stations[5] per

[1] Issue Brief: Overuse of Emergency Departments Among Insured Californians, California HealthCare Foundation, October 2006.
[2] Strong Medicine: Family Medicine's Fix for California's Fractured Health Care System, California Academy of Family Physicians.
[3] Shannon McConville and Helen Lee, Emergency Department Care in California: Who Uses It and Why?, California Counts, Public Policy institute of California, Volume 10, Number 1, August 2008.
[4] Data from the Office of Statewide Health Planning and Development.
[5] An Emergency Department station is a specific place within the emergency medical services department adequate to treat one patient at a time. Holding or observation beds are not included.

hospital ED have increased. In 2007, there were 355 EDs (down from 376 in 2000) with 6,204 ED stations, (up from 5,091 stations in 2000). ED visits in California increased from 9.6 million in 2000 to 10.4 million in 2007. Most visits to the ED do not result in an admission to the hospital. In 2007, only 16% of the 10.4 million ED visits resulted in admission to the hospital.[6] Hospitals reported in 2007 that approximately 3% of patients left the ED before being seen.[7]

Recent studies indicate that an increasing number of ED visits are for non-urgent conditions. A Public Policy Institute of California (PPIC) report examined overcrowding and the use of EDs for non-urgent conditions. The PPIC study found that Medi-Cal and Medicare patients have the highest visit rates in the state and that the high volume of ED visits is not driven by uninsured Californians. The study found that Medi-Cal patients are more likely than the uninsured or privately insured to use an ED for non-urgent or avoidable conditions.[8] Research also indicates that patients who don't receive preventive, primary, or ongoing care for chronic conditions instead receive episodic care, often delivered in the ED, at roughly three times the cost. When patients get care for chronic conditions in the ED, there is an impact on continuity of care. Patients end up being treated by multiple doctors thereby increasing the potential for duplicative lab work, X-rays, and other tests and adding unnecessary costs to the health care system.

Factors Contributing to Rising ED Use and Overcrowding

There are numerous potential reasons for the rising use of ED services. Research has identified the impact of the rising number of uninsured and underinsured persons who do not have access to a regular source of medical care. At the same time, studies also reveal that the ED has become a health care safety net for individuals who have private insurance, but who are unable to obtain appointments with primary care or specialty physicians in a timely manner. Individuals who are covered by public programs such as Medicare and Medicaid (Medi-Cal in California), may have trouble finding primary and specialty care providers willing to accept their coverage, possibly because of low reimbursement rates or other factors that make providers less likely to participate.

Physician groups, hospitals, health care advocates, researchers, and other stakeholders offer a diverse array of contributing factors highlighted below:

- ***Lack of Access to Primary and Preventive Care***. According to a study conducted by the California HealthCare Foundation (CHCF), California's EDs are increasingly used by individuals whose health conditions are not true emergencies. CHCF concluded that patients often believe that they have no alternatives for treatment and diagnosis when faced with a sudden illness or accident. The CHCF study further found that key drivers to ED use include: lack of access to preventive and immediate healthcare; lack of advice or information about managing immediate health care needs; lack of alternatives to the ED for immediate medical needs that occur both during and after business hours; and, to a lesser extent, prevalence of attitudes that foster the use of the ED for non-urgent care.[9]

[6] Data from the Office of Statewide Health Planning and Development (OSHPD).
[7] Ibid.
[8] Shannon McConville and Helen Lee, Emergency Department Care in California: Who Uses It and Why?, California Counts, Public Policy institute of California, Volume 10, Number 1, August 2008.
[9] Issue Brief: Overuse of Emergency Departments Among Insured Californians, California HealthCare Foundation.

Reports estimate that there are too few primary care physicians to care for the current population, much less to cover the projected demand for services in the next few decades. Many new physicians and medical students choose specialty care over primary care, in part because primary care physicians are at the low end of the pay scale for physicians. California has only 46 part-time primary care doctors for every 100,000 existing Medi-Cal beneficiaries, even though federal Medicaid guidelines recommend 60 to 80 primary care doctors per 100,000 patients.[10] In addition, a 2003 report indicates that only 55% of primary care physicians who were accepting new patients said they were also open to new Medi-Cal patients. The California Academy of Family Physicians, which represents the state's family physicians, reports similar findings.[11]

- ***Reduced Inpatient Capacity***. A shrinking supply of inpatient beds and, in some instances, the lack of staff available to support those beds, may be affecting patients' ability to access timely emergency care. In many hospital EDs, patients who have been admitted to the hospital end up being "boarded" in the ED, where they spend hours or even days waiting for an available hospital bed. Patients who are boarded are often forced to wait in ED hallways, waiting rooms or other available spaces which provide for limited privacy and decreased access to timely services, appropriate expertise and equipment specific to a patient's condition.[12] Boarded patients tie up emergency staff time and resources, ultimately limiting the ED's capacity for treating other patients. High numbers of boarded patients waiting for beds can lead to increased waiting times for new arrivals and raise the risk that the hospital will have to divert incoming ambulances to other sites. Half a million times each year – an average of once every minute – an ambulance carrying an emergency patient is diverted from an ED that is full and sent to one that is farther away.[13] Ambulance diversion adds transport time and delays in care which in some cases can be the difference between life and death and prevents the ambulance from responding to other emergencies.

- ***Workforce Shortages***. Shortages of qualified hospital staff pose a significant challenge to EDs. California is currently facing a nursing shortage. Ranking 49th in the nation in terms of the number of registered nurses (RNs) per capita, California has 585 RNs per 100,000 population – compared to the national average of 798 RNs per 100,000 population. According to the California Economic Development Department (EDD), California faces an additional shortfall of more than 109,600 RNs by 2010. An additional 25,400 licensed vocational nurses will also be needed by 2010.[14] The nursing shortage is compounded by an aging nurse workforce, a lack of educational programs, and a lack of qualified nursing faculty.[15]

  In addition to shortages of nurses and primary care physicians, California is experiencing shortages of on-call physician specialists, which can lead to further emergency room delays.

[10] Strong Medicine: Family Medicine's Fix for California's Fractured Health Care System, California Academy of Family Physicians.
[11] Ibid.
[12] Report Brief; The Future of Emergency Care in the United States Health System, Institute of Medicine of the National Academies, June 2006.
[13] Ibid.
[14] California's Nursing Shortage: Backgrounder, California Healthcare Association, September 30, 2002.
[15] Ibid.

California's EDs are required, both by federal law and state regulation, to maintain a roster of specialty physicians available for consultation and care during, and immediately following, emergency care. By law, a hospital must have a specialist available for emergency calls, within a reasonable amount of time, for every specialty service it provides. Yet, in many cases, staff and patients are waiting for hours for a specialist to respond.

- ***Hospital Closures***. Hospital closures have been cited as contributing to increased demand and ED crowding at the remaining facilities.[16] A significant number of hospitals have closed in California in the last decade, but research and anecdotal reporting reveal a complex mix of potential reasons for the growing number of closures. According to the California Hospital Association from 1996 to 2006, almost 80 hospitals closed in California, including 39 emergency departments. Nearly 70% of the closures were located in Southern California. Approximately 20% were located in Central and Northern California and the remaining hospital closures were located in the San Francisco Bay Area. Of the Southern California closures, 32% (25 hospitals) were closed in Los Angeles County alone.

  A study of hospital closures between 1995 and 2000 conducted for then-Attorney General Bill Lockyer identified financial hardship present at each hospital's closure.[17] As a group, the closed hospitals reported some of the worst financial indicators, such as very low operating margins and high accumulation of debt. According to the hospitals, there were three main issues associated with the closures, that the hospital: 1) was losing money, 2) had declining reimbursements, and/or 3) low utilization. A 2001 report prepared for CHCF[18] confirmed the financial deterioration of California hospitals for the period of 1995 through 1999 citing California's highly competitive market, patients with higher severity of illness, higher wages for full-time hospital employees, the nursing shortage, and a large uninsured population.

- ***Shifting Demographics***. Research also suggests that the use of ED services will continue to rise due to demographic factors, such as the increasing age of the population. The U.S. population is growing and life expectancies are increasing, leading to more people living longer with complex and chronic debilitating diseases such as diabetes, cancer, and renal failure.[19] Research also shows that adults with chronic conditions are disproportionately represented among recent ED users. While 32% of the California adult population suffers from hypertension, heart disease, diabetes, and/or chronic lung problems, 44% of recent ED users fit this description.[20] The patterns of ED use among the chronically ill raises concerns about the quality of care these patients receive and underscores the need for better ongoing management of their conditions. For patients with chronic conditions, getting care at the ED rather than from their regular source of care may contribute to problems with continuity of

[16] Hospital emergency departments: Crowded conditions vary among hospitals and communities, U.S. General Accounting Office (Publication No. GAO-03-460), 2003.
[17] Scheffler, Richard, California's Closed Hospitals, 1995-2000, Nicholas C. Petris Center on Health Care Markets and Consumer Welfare (Petris Center), University of California, Berkley, School of Public Health, January 2001, Revised April 2001.
[18] Issue Brief: Financial Challenges for California Hospitals, prepared for the California HealthCare Foundation, September 2001.
[19] Derlet, R.W. (2002). Overcrowding in emergency departments: increased demand and decreased capacity. Annals of Emergency Medicine, 39, 430-432.
[20] Issue Brief: Overuse of Emergency Departments Among Insured Californians, California Healthcare Foundation.

care.[21]

II. Innovative Projects

Currently there are a number of pilot projects that seek to both reduce health care costs and increase access to disease management and primary care. Many of the projects are specifically intended to reduce or eliminate excess use of the ED. Following are a few examples of such projects that are currently taking place in California:

Frequent Users of Health Care

A small number of individuals in many communities repeatedly and excessively utilize EDs and inpatient services as their primary source of medical care. These individuals usually have complex and chronic problems stemming from mental illness, alcohol, or substance abuse disorders, and homelessness, as well as multiple co-occurring disorders including mental illness and substance abuse, and often lack necessary social supports to help navigate the health care system and maintain continuity of care. While small in number, multiple studies reveal that these "frequent users" generate a disproportionately large share of medical care costs and use scarce hospital resources for conditions that could have been prevented or treated more appropriately in other lower cost community and primary care settings. In California, for example, the PPIC study reported that 5% of Medi-Cal patients utilized 60% of fee-for-service expenditures in 2003.[22]

In 2003, the Endowment and CHCF launched the Frequent Users of Health Services Initiative (Initiative) to address the issue of avoidable ED use by frequent user patients. The five-year Initiative focused on promoting a more responsive system of care to address patient needs, produce better outcomes, and re-direct ED resources toward acute medical crises. Six urban and rural sites throughout California, serving a total of 1,100 Medi-Cal patients, were funded through the Initiative to bring together multiple service providers and streamline care for this high risk population. Data from the project revealed that initially frequent users in the program averaged 8.9 ED visits per person each year, with average annual charges of $13,000 per patient; 1.3 hospital admissions per year; and 5.8 inpatient days per person each year, with average annual charges of $45,000 per patient. Findings from the final evaluation of the Initiative indicate that, compared to utilization in the year prior to enrollment, total ED visits decreased 38% during the first year of program participation and 60% during the second year. Inpatient admissions decreased 17% in the first year and were 67% less in the second year. In total, hospital inpatient and ED charges were $10.3 million less during year two of participation than they were during the year prior to enrollment. The data from the Initiative suggests that frequent user programs demonstrate dramatic cost offsets and can literally pay for themselves.

[21] Ibid.
[22] Shannon McConville and Helen Lee, Emergency Department Care in California: Who Uses It and Why?, California Counts, Public Policy institute of California, Volume 10, Number 1, August 2008.

Management of Chronic Disease

Patients with chronic diseases generally have higher overall use of ED services. Disease management (DM) is a set of interventions, such as patient education programs, that promote preventive self-care, that are designed to improve the health of individuals with chronic conditions such as diabetes, heart failure or asthma. DM programs provide an alternative to traditional patient care, and seek to avoid complications and disease progression. Patients are monitored actively, before onset of acute illness, with early and aggressive clinical intervention by the appropriate providers. Compared to traditional health care delivery models, DM shifts its focus from episodic and acute care to ongoing care for chronic illnesses that affect a targeted population of patients. This delivery model attempts to provide as much care as appropriate in an outpatient or home care setting while reserving inpatient or hospital care for patients who need acute interventions, advanced technologies or both.

In 2005-06, the Legislative Analyst's Office (LAO) concluded that that DM programs are an effective way to improve the health of chronic disease patients. The LAO estimated that, if utilized within Medi-Cal, these models could result in significant cost savings to the state. While the LAO report noted that "it is not yet clear which specific approaches to DM in Medi-Cal would work best and be most cost-effective," the report recommended that the Legislature direct the Department of Health Services (now the Department of Health Care Services (DHCS)) to conduct pilot projects in DM for three years.

Pursuant to AB 1762 (Committee on Budget), Chapter 230, Statutes of 2003, DHCS applied for a federal waiver to develop pilot programs to test the efficacy of providing a DM benefit to aged, blind, or disabled Medi-Cal fee-for-service beneficiaries or those beneficiaries over the age of 21 with targeted chronic diseases, including congestive heart failure, diabetes, asthma, and coronary artery disease. Currently, DHCS has implemented two pilot DM programs, in Alameda County and Los Angeles County, to serve beneficiaries with seven specified chronic conditions, including congestive heart failure, diabetes, asthma, coronary artery disease, and HIV/AIDS. DHCS indicates that an evaluation of first year results relating to financial, patient health, organizational, and clinical outcomes is expected in July 2009.

Primary Care Medical Home Model

Timely access to primary care is critical to lowering health care costs and improving the overall quality of care. Both insured and uninsured patients often have difficulty accessing such care when it is needed, leading to a significant percentage of inappropriate ED visits. The medical home model is based on the premise that the best quality of care is provided not in episodic, illness-oriented, complaint-based care, but through patient-centered, physician-guided, cost-efficient, long term care. This model of care is comprised of a team of health care professionals led by a primary care physician who provides preventive and acute care, manages chronic conditions, and ensures that patients receive the right care at the right time in the right setting. An established medical home depends upon the support of a health care system dedicated to nurturing its success and providing an adequate supply of primary care physicians. According to the California Academy of Family Physicians, numerous recent studies have shown that in markets where primary care physicians provide the majority of care, patients are healthier and costs are lower.

Several states are using the medical home model to successfully improve health outcomes and reduce avoidable ED visits, inpatient hospital stays and medical utilization. In February 2007, Illinois began mandatory enrollment of targeted Medicaid beneficiaries into its medical home program to focus on access and quality while managing costs. The program currently has 1.7 million participating members linked to 5,300 physicians and clinics that are serving as their medical homes. Pennsylvania's ACCESS Plus program provides a primary care case management medical home to 290,000 Medicaid members. Since its inception the program reports $823 annual savings per member and a reduction of 38 hospital admissions per 1000 members. The disease management component of the program achieved cost savings of $27 million in year one and $35 million in year two. North Carolina's medical home initiative, Community Care of North Carolina, provides care to more than 750,000 Medicaid recipients, relying heavily on patient-centered medical homes, population health management, case management services and community based networks to deliver care. The program encompasses 15 networks of 3,500 primary care physicians and 1,000 medical homes and has saved the state nearly half a billion dollars since it began in 1999.

III. Oversight and Regulation of Emergency Services

Federal Law

The Emergency Medical Treatment and Active Labor Act (EMTALA), often referred to as the federal “anti-dumping law,” was enacted by Congress in 1985 to ensure that patients who come to hospitals for treatment of potential emergency conditions are not turned away or transferred to another facility prematurely or refused treatment because of their inability to pay. EMTALA governs when and how a patient may be 1) refused treatment or 2) transferred from one hospital to another when he is in an unstable medical condition. EMTALA applies only to "participating hospitals" -- i.e., to hospitals which have entered into "provider agreements" under which they will accept payment from the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services under the Medicare program for services provided to beneficiaries of that program. In practical terms, this means that EMTALA applies to virtually all hospitals in the U.S., with the exception of the Shriners' Hospital for Crippled Children and many military hospitals. However, the provisions of EMTALA apply to all patients, and not just to Medicare patients.

Under EMTALA any patient who "comes to the emergency department" requesting "examination or treatment for a medical condition" must be provided with "an appropriate medical screening examination" to determine if he is suffering from an "emergency medical condition" prior to any inquiry as to the person's insurance status. If an emergency medical condition exists, then the hospital is obligated to either provide the patient with treatment until he is stable or, if the facility is not equipped to provide their care, to transfer him to another hospital in conformance with the statute's directives. A transfer to another facility before the patient has become stable can only take place if it is an "appropriate transfer." A transfer after the patient has become stable is permitted and is not restricted by EMTALA in any way. EMTALA's restrictions apply only to transfers before the patient has become stable, either on his own or as a result of medical treatment. EMTALA also provides that a pre-authorization requirement imposed by a managed care organization or a health insurer may not be allowed to prevent or delay the performance of a medical screening evaluation or prevent the institution from

providing necessary stabilizing treatment once it is determined that an emergency medical condition exists. EMTALA violations can subject hospitals to civil penalties up to $50,000 per violation.[23]

California Law

General acute care hospitals are required to be licensed and inspected by the State Department of Public Health (DPH).[24] General acute care hospitals are required to provide 24-hour inpatient care, including the following eight basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services.[25] In 2007, there were 428 licensed general acute care hospitals. General acute care hospitals are not required to maintain an emergency department, but they may be approved by DPH to offer special services[26], which is defined to include an emergency center, [27] and hospitals electing to offer emergency care must meet standards for special services adopted by DPH.

Under California law, consistent with the requirements of EMTALA, emergency services and care[28] are required to be provided to any person requesting services or care for any condition in which the person is in danger of loss of life, or serious injury or illness. This requirement applies to a health facility that maintains and operates an ED when the facility has appropriate facilities and qualified personnel available to provide the services or care. Emergency services and care are required to be rendered without first questioning the patient or any other person as to his or her ability to pay.[29]

IV. Related Legislation

Emergency Room Overcrowding

AB 2207 (Lieu) of 2008 would have required every hospital to access the condition of its emergency department every three hours and develop and implement capacity protocols to address overcrowding. AB 2207 was held in the Assembly Appropriations Committee.

Frequent Users

SB 1738 (Steinberg) of 2008, which was vetoed by Governor Schwarzenegger, would have required DHCS to establish a three-year pilot program to provide intensive multidisciplinary services to 2,500 Medi-Cal beneficiaries defined as frequent users of health care. Although the Governor indicated support for the author's intention to improve the health outcomes of disabled

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[23] 42 U.S.C. § 1395dd.
[24] Health and Safety Code Section 1254.
[25] Health and Safety Code Section 1250.
[26] Health and Safety Code Section 1252.
[27] Health and Safety Code Section 1255.
[28] Health and Safety Code Section 1317.1 defines “emergency services and care" as a medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.
[29] Health and Safety Code Section 1317.

Medi-Cal beneficiaries in his veto message, he asked the author and stakeholders to work with his Administration to identify a statewide solution that focuses on primary care and comprehensive coordinated care management.

Disease Management

AB 1736 (Levine) of 2005 would have required DHCS to test the efficacy of a specified treatment model in providing a DM benefit to eligible individuals with chronic diseases in community- or public hospital-based primary care settings. This bill was vetoed by Governor Schwarzenegger because it required a different model for chronic disease management that would have significantly increased costs to DHCS by expanding the scope of service for community clinics and health centers. The Governor's veto message also stated that it would have been difficult to obtain the data needed for the efficacy evaluation because the bundled rate of reimbursement of clinics does not show the individual services that are provided.

AB 1762 (Committee on Budget), Chapter 230, Statutes of 2003, directs DHCS to apply for a federal waiver to develop pilot programs to test the efficacy of providing a disease management benefit to aged, blind or disabled Medi-Cal fee-for-service beneficiaries or those beneficiaries over the age of 21 with targeted chronic diseases, including congestive heart failure, diabetes, asthma and coronary artery disease.

Physician Shortage

AB 2439 (De La Torre), Chapter 640, Statutes of 2008, requires the Medical Board of California (MBC) to assess a $25 mandatory fee for the initial license and license renewal of a physician and surgeon to support the Steven M. Thompson Program, which provides funds for physician loan repayment to physicians agreeing to practice in a medically underserved area. AB 2439 requires the Thompson Program to award up to 15% of fees to physicians who agree to provide care to geriatric or disabled adult populations.

SB 1379 (Ducheny), Chapter 607, Statutes of 2008, shifts the first $1 million of health plan fines from the Department of Managed Health Care (DMHC) annual administrative budget to the Thompson Program, and shifts the remaining funds above $1 million, to the Managed Risk Medical Insurance Program, for persons who are unable to obtain private health insurance because of a pre-existing medical condition.

AB 327 (De La Torre), Chapter 293, Statutes of 2005, authorizes MBC to collect from physicians a $50 voluntary donation upon initial issuance or biennial renewal of a physician and surgeon's license to support the loan repayment program. In 2006-07, $55,190 and in 2007-08 (through March 08) $51,647

AB 982 (Firebaugh), Chapter 1131, Statutes of 2002, created the Physician Corps Loan Repayment Program within the Medical Board of California (MBC), and the Medically Underserved Account (Account) within the MBC's Contingent Fund. AB 982 authorized MBC to transfer $3.45 million over three years from its Contingent Fund into the Account to fund the Physician Corps Loan Repayment Program.

Hospital Closures

AB 2400 (Price), Chapter 459, Statutes of 2008, requires hospitals to notify the public and the appropriate regulatory entity at least 30 days prior to closing a facility, eliminating a supplemental service, or relocating a supplemental service.

AB 2103 (Gallegos), Chapter 995, Statutes of 1998, requires hospitals to notify DHCS and the public 90 days in advance of closing or downgrading emergency services, and requires a county or its designated local emergency medical services agency to complete an impact evaluation of a proposed emergency services downgrade or closure. AB 2103 also requires DHCS to receive the community impact evaluation prior to "approving" the downgrade or closure of emergency services.

Primary Care Access

AB 1134 (Dymally) of 2007 would have permitted cities and counties to establish medical enterprise zones with the goal to promote primary care in poor areas of the state. AB 1134 died in the Assembly Revenue and Tax Committee.

AB 2179 (Cohn), Chapter 797, Statutes of 2002, directs DMHC to develop and adopt regulations to ensure that enrollees have timely access to needed health care services. DMHC has promulgated draft regulations to implement AB 2179. The regulations impose detailed and specific requirements on health plans and their providers, including requirements that health plans ensure that enrollees are able to see primary care providers within specified timelines, depending on the severity of the illness or complaints. The regulations are currently in the public comment phase.